STATE OF WYOMING DEPARTMENT OF HEALTH, RURAL AND FRONTIER HEALTH DIVISION
END STAGE RENAL DISEASE PROGRAM
6101 Yellowstone Road, Suite 510, Cheyenne Wyoming 82002
Office: (307)777-3527

APPLICATION FOR END STAGE RENAL DISEASE PROGRAM

Applicant's Name _____
Last First Middle Initial

Physical Address _____

City_____ State _____ Zip_____ Phone # (_____)_____

Mailing Address (P.O Box / Street #) _____

City _____ State _____ Zip _____

SSN#_____-_____ -_____ Date of Birth (MM/DD/YY) _____/_____/_____

Applicant's Primary Physician _____ Phone _____

Applicant's Nephrologist _____Phone _____

Primary Dialysis Clinic _____ Phone _____

Date of First Dialysis _____/_____/_____ Transplant Yes/No If Yes - Date_____/_____/_____

Marital Status: S M W Sep Number In Household: _____ Number of Dependent Children _____

Total Gross Household Income (**Before Taxes**) Yearly $ _____ / Monthly $_____

Family member or Friend whom we may contact if unable to contact you:

_____Phone_____

I (Applicant's Name) _____am applying for assistance by the Wyoming Department of Health, End Stage Renal Disease Program. I am unable to pay for the recommended Treatment. I will apply all hospital and or medical insurance and Medicare benefits I receive to the cost of my Care.

I UNDERSTAND THAT THE END STAGE RENAL DISEASE PROGRAM WILL ONLY PAY FOR SERVICES / EXPENSES RELATED TO ESRD ACCORDING TO ESRD PROGRAM POLICIES & PROCEDURES.

ALL INFORMATION I HAVE GIVEN ON THIS CONFIDENTIAL APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant's Signature_____ Date: _____

Preliminary Eligibility Determination at Dialysis Center (Case Worker Please Complete)

Print / Sign Case Worker: _____Phone: _____

ESRD PROGRAM OFFICE USE ONLY

Financially Eligible Yes or No ESRD Program: _____ (Initials) Date: _____
(If applicant does not qualify due to financial guidelines, a letter is sent to applicant; the application is not sent to the Director/State Health Officer).

Medically Eligible Yes or No

Director/State Health Officer: _____Date:_____

Health Insurance

A. **Do you have private health insurance?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your insurance cards.

Health Insurance Company Name	Type of Coverage	Effective Date	Policy Number
Monthly Premiums (Applicant only)	**$**		

B. **Do you have Medicare?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your Medicare card.

Type of coverage (check each box that applies)	Effective Date	Medicare ID Number
Part A ☐ Part B ☐ Part D ☐		
Monthly Premiums	Part B **$**	Part D **$**

C. **Do you have Medicaid?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your Medicaid card.

Type of Coverage	Effective Date	Medicaid ID Number

Primary Dialysis Center Information

Dialysis Center Name:			
Address:			
City:	State:	Zip:	
Social Worker Name:			
Phone Number:			
E-Mail:			

END STAGE RENAL DISEASE PROGRAM

Confidential Financial Statement

APPLICANT'S INFORMATION

Name _____
Last First MI

Address _____
Number/Street/Apt. City State ZIP Code

Birth Date _____Gender: Male / Female

Telephone Number ( ) _____

Number of persons in household _____

Relationship to applicant _____

APPLICANT'S PERSONAL INCOME	**OTHER HOUSEHOLD MEMBER'S INCOME**
Employer / Occupation _____	Employer / Occupation _____
City/State _____	City/State_____
Gross Earnings from Employer $_____	Gross Earnings from Employer $_____
Monthly Social Security $_____	Monthly Social Security $_____
Monthly Retirement Income $_____	Monthly Retirement Income $_____
Monthly Disability Income and Source $_____ _____	Monthly Disability Income and Source $_____ _____
Monthly Income any other Source $_____	Monthly Income any other Source $_____
Total Gross Income Last Year $_____	**Total Gross Income Last Year $**_____
➔ **Attach a Filed Copy of your most recent Income Tax Return or if you do not file, then your Benefit Letter from Social Security for the current year or any other documentation of income if not taxable.**	➔ **Attach a Filed Copy of your most recent Income Tax Return or if you do not file, then your Benefit Letter from Social Security for the current year or any other documentation of income if not taxable.**

BUSINESS, FARM, OR OTHER INCOME	**Amount $**
Yearly Farm or business Income (if listed, please attach an itemized statement of business income and expenditures).	
Yearly Income from any sources other than shown above (rental property you own, dividends, welfare, unemployment compensation, per capita payments, part - time, second jobs, child support, etc.).	

FINANCIAL DATA

Monthly Medical Expenses

Medical Insurance Information - Applicant Only

Company	Policy Holder	Policy #	Monthly Premium *

***[If the medical insurance premium covers both applicant and spouse and/or children put applicant's share only of the premium in the Monthly Premium box.]**

Expense	Monthly Amount
Housing (monthly payment) rent own	

Applicant's Medical Payments

	Monthly Payment	Balance Owed
Physician		
Hospital		
Dental		
Prescriptions		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		

Assets (Applicant and Spouse)

Estimated Market Value of Home	
Value of Other Real Estate	
Stocks and/or bonds (name and value)	
Name of Bank	
Amount in Savings	
Amount in Checking	
Farm or business equipment value	
Other Assets (Type and Value)	

I (Applicant)_____ am applying for assistance from the End Stage Renal Disease Program, Department of Health. I am unable to pay for the recommended treatment. I will apply any hospital and or medical insurance and Medicare and/or Medicaid benefits I receive to the cost of my care. I will pay Medicare and/or Medicaid and other insurance premiums to provide coverage. I understand that the End Stage Renal Disease Program must give prior authorization for any care for which it is to pay.

All information I have given on this confidential financial statement and application is true to the best of my knowledge.

Signed_____Date_____

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Authorization to Furnish Information

Patients Name _____

Date of Birth _____

The information you have provided will remain confidential with the Department of Health**, EXCEPT** in the following circumstances:

The End Stage Renal Disease Program (ESRD) as part of the Department of Health is a covered entity. ESRD may request from any state agency, insurer, group health plan, health maintenance organization or similar entity any or all of your protected health information. This information includes the recipient's name, social security number, amount of payment, charge for services, date of services, and services rendered related to medical payment. This information may be used or disclosed for the process of treatment, payment or healthcare operations. This is in accordance with the Health Information Portability and Accountability Act section 164.502(a)(1)(ii). Please see your Client Privacy Rights Policy for use and disclosure of your protected health information.

I hereby authorize the release of information limited to payment information (as described above) to state agencies, insurers, group health/dental plans, third party administrators, health maintenance organizations or similar entities for the purpose set forth above**.**

End Stage Renal Disease Program provides financial assistance in payment of medical bills and prescriptions for those who have the diagnosis of End Stage Renal Disease. For those individuals that have had a kidney transplant the program only covers immunosuppressant medication.

By signing this consent, I give my permission to medical health care providers, hospitals, and free standing Dialysis Centers to release confidential medical information.

A photo copy or reproduction of this authorization is as valid as the original.

Signature_____ Date_____

Signature of Witness_____ Date_____

Assistance Requested

The financial ability to help with payments for services is restricted to those specifically related to Dialysis or to the payment for immunosuppressant medication for those who have had a transplant. Please complete the following so that the ESRD program can tell you specifically which items will be covered now and allow the program to assess the need for covering more items.

I Need Assistance With:

- ☐ Transplant Applicants, Only Prescription's for Immunosuppressant's are reimbursed.
- ☐ Prescription costs (ESRD Medications Only).
- ☐ Co-payment after Medicare and or Private Health Insurance have paid for dialysis and office visits related to ESRD.
- ☐ Reimbursement of private medical insurance premium.
- ☐ Reimbursement of Medicare premium.
- ☐ Reimbursement of cost of Medical supplies for Home dialysis.
- ☐ Mileage and travel to Dialysis, (For travel outside your city of residence only).
  Home Address: _____
  City _____ State _____ Zip _____
  No P O BOXES
  We will provide you with map miles to your dialysis center
- ☐ Other _Must have approval by the ESRD Program.

_____

_____

_____ _____

Print Name and Sign Date

ESRD 6/2008

CHECK LIST

HAVE YOU:

- ☐ **Filled out the application completely;**
- ☐ **Read the authorization statement;**
- ☐ **Signed and dated application;**
- ☐ **Had your social worker sign and date application;**
- ☐ **Included a photocopy of your income tax return for the current year;**
- ☐ **Included proof of income;**
- ☐ **Included Social Security statements;**
- ☐ **Included your HCFA-2728-U3 Medical form from physician;**
- ☐ **Included photocopies of all your health coverage identification cards;**
- ☐ **Included your physical address along with your mailing address.**

State of Wyoming – Department of Health – Rural and Frontier Health Division
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